ANATOMY & TERMINOLOGY

Quick Reference Guide for Anesthesia Coders & Auditors

Core Principle: Anesthesia coding is anatomy-driven. Translate the operative documentation into the body region, anatomical structure, procedure, and approach before selecting an anesthesia code or evaluating a regional block.

1. Anatomical Directional Terms

Term	Meaning
Anterior / Ventral	Toward the front of the body.
Posterior / Dorsal	Toward the back of the body.
Superior / Cephalad	Toward the head or above another structure.
Inferior / Caudad	Toward the feet or below another structure.
Medial	Toward the body's midline.
Lateral	Away from the body's midline.
Proximal	Closer to the trunk or point of origin.
Distal	Farther from the trunk or point of origin.
Superficial	Closer to the body surface.
Deep	Farther from the body surface.

2. Anatomical Planes & Positions

- Sagittal: Divides the body into right and left portions.
- Coronal / Frontal: Divides the body into anterior and posterior portions.
- Transverse / Axial: Divides the body into superior and inferior portions.
- Oblique: Divides the body or structure at an angle between the standard anatomical planes.
- Supine: Lying on the back, face upward.
- Prone: Lying on the abdomen, face downward.
- Lateral decubitus: Lying on the right or left side.
- Lithotomy: Supine with the hips and knees flexed and the legs elevated and supported.
- Trendelenburg: Supine with the head lower than the feet.
- Reverse Trendelenburg: Supine with the head higher than the feet.

3. Major Body Regions Used in Anesthesia Coding

Region	Coding Orientation
Head / Face / Neck	Cranium, intracranial structures, facial structures, eye, oral cavity, pharynx, larynx, and cervical region.
Thorax	Chest wall, lungs, pleura, mediastinum, heart, and great vessels.
Upper Abdomen	Stomach, liver, gallbladder and biliary system, spleen, pancreas, and related upper-abdominal structures.
Lower Abdomen / Pelvis	Bowel, appendix, bladder, reproductive organs, and other pelvic structures.

Region	Coding Orientation
Spine	Cervical, thoracic, lumbar, and sacral regions; identify the documented spinal region, level(s), and surgical approach when relevant.
Upper Extremity	Shoulder -> arm -> elbow -> forearm -> wrist -> hand.
Lower Extremity	Hip -> thigh -> knee -> leg -> ankle -> foot.
Perineum	Region between the thighs involving structures of the anal, perianal, and external genital areas.

Chart Talk Anatomy Pearl: The operative procedure - not the diagnosis alone - should drive your anatomical analysis. Identify what structure was actually treated, where it is located, and what procedure was performed before selecting the anesthesia code.

4. Procedure Terminology: Know the Word Parts

Word Part	Meaning
-ectomy	Surgical removal / excision.
-otomy	Incision into / cutting into.
-ostomy	Creation of an artificial opening.
-plasty	Surgical repair / reconstruction.
-pexy	Surgical fixation / suspension.
-rrhaphy	Surgical suturing / repair.
-scopy	Visual examination using a scope.
-centesis	Surgical puncture, typically to aspirate or remove fluid.
-lysis	Loosening, separation, breakdown, or destruction.
-desis	Surgical fixation / fusion.
arthr/o	Joint.
neur/o	Nerve.
my/o	Muscle.
oste/o	Bone.
angi/o	Vessel.
vas/o	Vessel / duct.
lapar/o	Abdomen / abdominal wall.

Chart Talk Terminology Pearl: A word part helps you understand what may have been performed, but it does not replace reading the complete operative description. Translate the entire procedure into anatomy + action + approach before selecting the anesthesia code.

5. Regional Anesthesia Terminology

Term	Coder-Friendly Meaning
Neuraxial anesthesia / analgesia	Techniques involving the spinal or epidural spaces, most commonly spinal, epidural, or combined spinal-epidural techniques.
Spinal / subarachnoid	Medication delivered into the subarachnoid (intrathecal) space.
Epidural	Medication delivered into the epidural space, outside the dura.
Peripheral nerve block	Local anesthetic deposited near a peripheral nerve or nerve plexus to produce anesthesia or analgesia in its distribution.

Term	Coder-Friendly Meaning
Plexus	A network of intersecting nerves, such as the brachial or lumbar plexus.
Fascial plane block	Local anesthetic deposited within a defined anatomical tissue plane, with the intended effect occurring through nerves traveling within or associated with that plane.
Single injection	A block performed using a one-time injection rather than placement of a continuous catheter.
Continuous catheter	A catheter positioned at or near the target nerve, plexus, or anatomical plane to permit ongoing or repeated administration of local anesthetic.
Dermatome	An area of skin primarily supplied by sensory fibers from a single spinal nerve root.
Motor block	Reduction or loss of motor function resulting from neural blockade.
Sensory block	Reduction or loss of sensation within the affected neural distribution.

Regional Anatomy Pearl: A block name may describe a nerve, plexus, anatomical location, approach, or fascial plane. Do not assume the block name alone identifies the structure being targeted. Review the documented anatomy and location of blockade.

6. Nerve Anatomy: High-Yield Relationships

- Brachial plexus -> Major nerve network supplying the upper extremity. Primarily formed from C5-T1 and organized as roots -> trunks -> divisions -> cords -> terminal branches.
- Femoral nerve -> Major nerve of the anterior thigh; provides motor innervation to the quadriceps and gives rise to the saphenous nerve.
- Saphenous nerve -> Sensory terminal branch of the femoral nerve that travels distally through the adductor canal region.
- Sciatic nerve -> Major nerve supplying much of the posterior thigh and lower leg; ultimately separates into tibial and common fibular (common peroneal) components.
- Obturator nerve -> Supplies the medial thigh/adductor region and has both motor and sensory functions.
- Lateral femoral cutaneous nerve -> Sensory nerve supplying the anterolateral/lateral thigh.
- Suprascapular nerve -> Branch of the brachial plexus that provides motor and sensory innervation associated with the shoulder.
- Intercostal nerves -> Anterior rami of thoracic spinal nerves that travel within the intercostal spaces and provide motor and sensory innervation to the thoracic wall.

Chart Talk Anatomy Pearl: A nerve and the anatomical location where that nerve is approached are not necessarily the same thing. Terms such as adductor canal, popliteal, interscalene, and supraclavicular may describe an anatomical region or approach. Determine the documented neural target before selecting a code.

7. Surgical Approach Terminology

Approach	Meaning
Open	Procedure performed through a surgical incision that provides direct exposure of the operative site.

Approach	Meaning
Percutaneous	Access through the skin, typically using a needle, wire, catheter, or other device without an open surgical incision.
Endoscopic	Procedure performed using an endoscope through a natural or surgically created access route.
Laparoscopic	Endoscopic approach into the abdominal or pelvic cavity through small abdominal incisions/ports.
Arthroscopic	Endoscopic approach used to visualize and perform procedures within a joint.
Transcatheter	Procedure performed through catheter-based vascular or other applicable access.
Anterior / Posterior approach	Describes the direction of surgical access; particularly important when interpreting spine and orthopedic procedures.

Chart Talk Coding Pearl: Surgical approach can be an important part of understanding the procedure, but do not select an anesthesia code from the approach alone. Identify the anatomical site + procedure performed + documented approach, then verify the most specific supported anesthesia code.

8. Terms That Can Change Coding Interpretation

- Resection vs. excision: Determine the specific structure involved and the extent of tissue or structure removed. Do not assume the terms are interchangeable in every coding context.
- Repair vs. reconstruction: Identify the structure treated and what was actually performed, including graft, implant, or fixation when relevant.
- Fusion: Identify the anatomical region, level(s), surgical approach, and other procedure details relevant to code selection.
- Revision: Do not assume revision means removal. Determine what was revised, replaced, repositioned, repaired, or removed.
- Exploration: Determine the anatomical area explored and whether another definitive procedure was performed.
- Biopsy: Identify the anatomical site and documented technique.
- Decompression: Identify what structure is being decompressed and at what anatomical site or level.
- Fracture treatment: Identify the bone, specific location/segment, treatment performed, and fixation method when relevant.

Chart Talk Terminology Pearl: Procedure words are clues - not complete coding answers. When a term such as revision, reconstruction, decompression, or exploration appears in the record, read further to determine what structure was treated, what was actually done, and where it occurred.

9. Chart Talk Anatomy & Terminology Audit Red Flags

- Code selected from a procedure nickname rather than the documented anatomy and procedure performed.
- Assuming similarly named blocks target the same nerve or structure.
- Confusing a nerve or plexus with the anatomical location or approach where the block was performed.
- Failing to distinguish proximal from distal anatomy or approaches when the distinction affects code selection.
- Selecting a general anesthesia code when the documented procedure supports a more specific code.

- Selecting the anesthesia code from the diagnosis alone rather than determining the procedure actually performed.
- Missing anatomical specificity such as laterality, spinal region/level, joint, bone or bone segment, nerve/plexus, or surgical approach when relevant to code selection.
- Treating an abbreviation as definitive when the abbreviation could reasonably represent more than one term.
- Allowing the scheduled procedure or case title to override the final operative documentation when the procedure actually performed differs from what was originally planned.

Chart Talk Audit Reminder: When the terminology and anatomy do not agree, stop and investigate. Do not make the documentation fit the code. Determine what the record actually supports and follow the appropriate clarification, query, or escalation process when a material ambiguity remains.

10. Chart Talk Quick Anatomy-to-Code Workflow

Step	Action	What the Coder Should Determine
1	Translate	Rewrite the procedure in plain anatomical language. What actually happened?
2	Locate	Identify the body region and the exact anatomical structure involved.
3	Define	Determine what was performed - repair, excision, fusion, scope, block, catheter placement, etc.
4	Approach	Identify the documented approach when relevant - open, percutaneous, endoscopic, anterior/posterior, or regional-block location/approach.
5	Specifics	Identify relevant details such as laterality, spinal level, segment, joint, nerve, plexus, or fascial plane.
6	Code	Match the documented anatomy and procedure to the most specific supported code.
7	Verify	Verify against current CPT/ASA guidance, applicable NCCI requirements, and payer policy.
8	Query	Clarify material ambiguity when documentation is insufficient; do not assume or guess.

Chart Talk Note: This workflow is an educational framework for approaching anatomy-based coding questions. It is not a CMS- or CPT-mandated coding sequence.

Coder's Bottom Line

Don't code the word - code the anatomy. Identify where the procedure occurred, the anatomical structure involved, what was done to that structure, and how the procedure was approached. For regional anesthesia, distinguish the nerve or plexus being targeted from the anatomical location or approach used to reach it.

Translate the documentation into anatomy + procedure + approach + relevant specifics, then verify the most specific supported code using current authoritative guidance.

When the anatomy or terminology is unclear, conflicting, or materially incomplete, do not guess. Follow the appropriate clarification, query, or escalation process.

Authoritative References to Verify

- AMA - Current CPT code set and official CPT guidelines, including applicable anesthesia and procedure guidance.
- American Society of Anesthesiologists - Current Relative Value Guide and applicable anesthesia coding resources.
- ASRA/ESRA - Regional anesthesia nomenclature and anatomical terminology resources, when applicable to interpreting regional anesthesia documentation.
- CMS - Medicare National Correct Coding Initiative Policy Manual, including current anesthesia and general correct-coding guidance.
- Applicable Medicare Administrative Contractor, Medicaid, and commercial payer policies when coverage, reporting, or anatomical specificity requirements are payer-dependent.
- Recognized anatomy and medical terminology references when additional anatomical clarification is necessary.

Source Verification Note: Coding guidance, code descriptors, NCCI edits, payer policies, and reporting requirements may change. Verify current authoritative guidance applicable to the date of service before making a final coding or billing determination.

Educational Use Only

This quick reference is intended for coding and auditing education. It does not replace current CPT, ASA, CMS, NCCI, MAC, Medicaid, commercial payer, organizational, contractual, legal, or compliance guidance. The inclusion or discussion of a code, anatomical structure, procedure, technique, or billing concept does not guarantee coverage or reimbursement.